Physician's Medical Necessity Certification

Complete for non-emergency scheduled and non-emergency unscheduled ambulance transport(s)

(This applies to Repetitive Transports and/or One-Time Transports)

PATIENT'S NAME		HEALTH INSURANCE CLAIM NUMBER (HIC)
TRANSPORT DATE	TRANSPORTED FROM	TRANSPORTED TO

In order for ambulance services to be covered, they must be medically necessary and reasonable. Medical necessity is established when **the patient condition is such that transportation by any other means is contraindicated.** Please complete the questions below in order for the ambulance claim to be evaluated under Medicare coverage criteria.

The Health Care Financing Administration has defined "**bed confinement**" as (***all three bullets must be met***):

The patient is:

- unable to get up from bed without assistance;
- unable to ambulate; **and**
- unable to sit in a chair or wheelchair.

1) Is the patient bed-confined as defined by the above definition? ❑ Yes ❑ No

2) If **No**, please check the **appropriate medical conditions listed below.**

This patient:

❑ requires restraints to prevent harm and/or injury to self or others (**provide explanation in other**)

❑ requires cardiac monitoring

❑ requires continuous oxygen monitoring by training staff **Note: patients who are generally mobile with portable oxygen would not require non-emergency ambulance transportation based solely on the need for oxygen.**

❑ had to remain immobile because of a fracture that had not been set or the possibility of a fracture (i.e., hip fracture)

❑ is ventilator dependent

❑ requires continuous IV therapy

❑ other, please specify, _____

_____

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS, TO THE BEST OF MY KNOWLEDGE, COMPLETE AND ACCURATE AND SUPPORTED IN THE MEDICAL RECORD OF THE PATIENT. THE INFORMATION BEING UTILIZED ON THIS FORM IS BEING GATHERED TO ASSIST IN SEEKING REIMBURSEMENT FROM THIRD PARTY PAYERS SUCH AS THE MEDICARE PROGRAM. I UNDERSTAND THAT ANY INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION, WHICH LEADS TO INAPPROPRIATE PAYMENTS, MAY BE SUBJECT TO INVESTIGATIONS UNDER APPLICABLE FEDERAL AND/OR STATE LAWS.

PHYSICIAN NAME	PHYSICIAN TELEPHONE NUMBER
PHYSICIAN ADDRESS	
PHYSICIAN SIGNATURE	DATE

Physician Certification is good 60 days from date of physician's signature